Wellness Center Authorization to Treat

I understand that the health care information provided by me and gathered at visits to the SMCM Wellness Center is confidential. I agree that all such healthcare information may be used and shared by the providers in the Wellness Center to ensure a continuity of care with issues that require medical and psychological co-management and I authorize them to share this information on a need-to-know basis. I hereby waive any and all claims against SMCM and its employees arising from the use and sharing of such information. I understand that my health care information will not be shared outside the Wellness Center without my consent.

Student Name (Print): _____SMCM ID Number: _____

_____

Student Signature (over age 18): Date:

_____

Signature of Parent/Guardian of Minor/Student (under age 18) Date:

Authorization for SMCM Wellness Center and neighboring hospitals

If I require emergency treatment at SMCM Wellness Center or neighboring hospitals AND I AM UNABLE TO PROVIDE CONSENT TO TREATMENT, I hereby give permission for emergency medical treatment, INCLUDING SURGERY, which the attending physician considers necessary.

IF A MINOR IS INVOLVED, ordinarily the attending physician will ATTEMPT TO CONTACT the parent or guardian before major surgery is performed. WHERE A MINOR IS INVOLVED, this permission RELATES to an emergency in which the parent or guardian cannot be contacted AND DELAYING THE TREATMENT OR SURGERY POSES a serious RISK to the student.

Student Name (Print): _____SMCM ID Number: _____

_____

Student Signature (over age 18): Date:

_____

Signature of Parent/Guardian of Minor/Student (under age 18) Date: